STATE OF MONTANA
Department of Public Health and Human Services

Personal Assistance Services/Community First Choice
Agency Discharge/Unable to Admit Sheet

☐ AB-CFC ☐ SD-CFC ☐ ABPAS ☐ SDPAS

Submit Form to Mountain Pacific Quality Health (Fax 1-800-268-5767)

Consumer Name: _____ _____
(Last) (First) (MI)

Medicaid Id#: _____ **Discharge Date:** _____

Discharge Code: (Check all that apply)

____ **Death**
____ **Nursing Home Placement**
____ **Hospital Placement**
____ **Medicaid Ineligibility**
____ **Consumer Request**
____ ***Moved From Service Area**
____ ***Agency Not Able to Meet Needs**
____ ***Requested Services from Another Agency**
____ **Goals Met**
____ **Other (Specify)** _____
_____

* **Consumer requests referral sent to:** _____
(Agency) (City)

Unable to Admit Code: (Check all that apply)

_____ **Death**
_____ **Consumer's Location**
_____ **Consumer Moved**
_____ **Consumer Refused Service**
_____ **Hospitalization**
_____ **Medicaid Ineligible**
_____ **Nursing Home Placement**
_____ **Selected Another Provider**
_____ **Selected Another Service Option**
_____ **Too Few Hours Authorized to Staff**
_____ **Unable to get HCP Authorization**
_____ **Unable to get PR**
_____ **Unable to Reach Consumer**
_____ **Unable to Schedule Intake Visit**
_____ **Unable to Staff**
_____ **Other (Specify)**
_____

Narrative: (If necessary)

Signature: _____ **Date:** _____

Agency: _____